STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	08/25/2011

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MADISON HEALTH CARE CENTER, LLC	7465 MADISON AVENUE INDIANAPOLIS, IN46227

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 22, 23, 24, and 25, 2011 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Survey team: Leia Alley, RN, TC Marcy Smith, RN Barbara Hughes, RN Karina Gates, BHS Courtney Mujic, RN Patty Allen, BSW Census bed type: SNF: 13 SNF/NF: 47 Total: 60 Census payor type: Medicare: 17 Medicaid: 28 Other: 15 Total: 60 Sample: 15 These deficiencies reflect state findings	F0000	**This plan of correction is to serve as Madison Health Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Madison Health Care Center or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Madison Health Care Center is in compliance as of September 24, 2011. We respectfully request paper review.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2. Quality review 9/01/11 by Suzanne Williams, RN			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure physician's orders were followed in regard to monitoring blood glucose levels, medication administration, wearing TED hose, and lab work, for 7 of 15 residents reviewed for following physician orders in the sample of 15. (Residents #35, 20, 27, 19, 24, 12, 36) Findings include: 1. The clinical record for Resident #35 was reviewed on 8/24/11 at 2:00 p.m. The diagnoses for Resident #35 included, but was not limited to: peripheral artery disease, osteoarthritis, and diabetes mellitus type II. A recapitulation of the July 2011 physician's orders for Resident #35 indicated Resident #35 was to have an Accucheck (a blood test to determine the glucose level in the blood) QID (4 times daily) at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m.	F0282	**F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN** It is the practice of Madison Health Care Center to provide services by qualified persons in accordance with each resident's written plan of care. I. Resident #35, #24, #12, and #36 blood sugars are being monitored and insulin is being administered according to the physician's order. Physicians are notified per call parameters. Resident #20 is receiving medication according to the physician's orders. Resident #27 is wearing TED hose as ordered. As noted in the survey report, the lab tests (hemoglobin and hematocrit) for Resident #27 were discontinued; the hemocult stool has been completed as ordered. Resident #19 is receiving medication as ordered. Resident #36 is receiving medication as ordered and blood pressure and heartrate are being checked according to the plan of care. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. The facility policy regarding medication administration and documentation	09/24/2011

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	The Blood Glucose/Sliding Scale Coverage Flowsheet for Resident #35 did not indicate an Accucheck was done on the following dates and times: 7/23/11 at 8:00 p.m., 7/24/11 at 4:00 p.m. and 8:00 p.m., 7/25/11 at 4:00 p.m. and 8:00 p.m., 7/27/11 at 11:00 a.m., 4:00 p.m. and 8:00 p.m., 7/28/11 at 6:00 a.m. and 11:00 a.m., 7/29/11 at 11:00 a.m., 7/30/11 at 8:00 p.m., and 7/31/11 at 8:00 p.m. Interview with the East ADON (Assistant Director of Nursing) on 8/25/11 at 10:08 a.m. indicated there was no documentation to verify Accuchecks were done on the above dates and times. 2. The clinical record for Resident #20 was reviewed on 8/23/11 at 9:30 a.m. The diagnoses for Resident #20 included, but were not limited to: Parkinson's disease, gastroesophageal reflux disease, dysphagia, obstructive sleep apnea, hypertension, and hydrocephalus. The July 2011 physician's recapitulation order for Resident #20 indicated 2 tabs of Divalproex ER tab 500 mg to be taken PO (by mouth) q (every) hs (night). The July 2011 MAR (Medication Administration Record) did not indicate the medication was given on 7/15/11, 7/24/11, 7/27/11, and 7/28/11.		practices has been reviewed. Licensed nurses have been re-educated on this policy. This re-education stressed the importance of documenting medications and treatments as they are performed to avoid incomplete documentation. The blood glucose monitoring flow sheets have been reviewed and revised to ensure improved documentation. IV. The Director of Nursing or her designee is conducting quality improvement audits of medication and treatment documentation. A random sample of 5% of resident's medication records, treatment records, and blood glucose flow sheets are being checked to ensure documentation is complete. This audit will be completed three times weekly for 30 days; then weekly for 30 days; then monthly for 6 months. The pharmacy consultant will assist in monitoring during routine monthly visits. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	

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	The July 2011 physician's recapitulation order for Resident #20 indicated Ranitidine 150 mg to be taken PO BID (twice a day) at 9:00 a.m. and hs (at night). The July 2011 MAR did not indicate the medication was given at night on 7/15/11, 7/16/11, 7/24/11, 7/27/11 and 7/28/11. The July 2011 physician's recapitulation order for Resident #20 indicated Pantoprazole tab 20 mg to be taken PO daily at 8:00 a.m. The July 2011 MAR did not indicate the medication was given on 7/15/11, 7/24/11, 7/27/11 and 7/28/11. Interview with the East ADON on 8/25/11 at 10:08 a.m. indicated there was no documentation to verify the medications were given, as ordered, on the above dates and times. 3. a. Resident #27's clinical record was reviewed on 8/22/2011 at 2:00 p.m. The record contained documentation of Resident #27 having been admitted to the facility on 7/6/2011, with diagnoses that included, but were not limited to, coronary artery disease, dementia, anemia, and hyperthyroidism. The clinical record included a physician's order dated 8/10/2011 for knee high TED Hose compression stockings to bilateral lower extremities to be on at 8:00 a.m.			

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	and off at 8:00 p.m.; these times were per resident request. Resident #27 was observed on 8/22/2011 at 2:40 p.m. to be not wearing any TED Hose compression stockings. Resident #27 was observed on 8/24/2011 at 2:10 p.m. to be not wearing any TED Hose compression stockings. b. Resident #27's clinical record included a physician's order dated 7/14/2011 for a Hemoccult stool times 1, and a Hemoglobin and Hematocrit level to be drawn weekly. Documentation to indicate these lab tests were completed, or of their results, was not in the record. Interview with the DON (Director of Nursing) on 8/23/2011 at 9:25 a.m. indicated that these labs were missed and not completed. The Nurse Practitioner reordered the Hemoccult stool and discontinued the weekly Hemoglobin and Hematocrit level on 8/23/2011. 4. Resident #19's clinical record was reviewed on 8/23/2011 at 10:00 a.m. The record contained documentation of Resident #19 having been admitted to the facility on 4/27/2011, with diagnoses that included, but were not limited to, Parkinson's disease, coronary artery disease, hyperlipidemia, and right hip			

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	fracture. Resident #19's clinical record included a medication administration record that showed doses were not documented as given for the following medications on 7/27/2011: Mirapex ER 0.375 MG tablet by mouth daily. Senna 8.6 MG tablet by mouth daily. Vitamin D-3 400 IU 2 tablets by mouth daily. The missing documentation of the medications was brought to the attention of the Administrator on 8/23/2011 at 4:45 p.m. No additional information was provided. 5. The clinical record of Resident #24 was reviewed on 8/25/11 at 11:00 a.m. Diagnoses included, but were not limited to, Diabetes. Review of Physician Orders included an order, dated 7/15/11, for "Novolog 4 units c [with] each meal, sliding scale accu check AC et HS [bed time]." Review of the Blood Glucose/Sliding Scale Coverage Flowsheet, on 8-25-11 at 4:30 p.m., indicated the HS accuchecks were not done as ordered by the physician on the following dates: July 15, 2011 July 22, 2011			

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	July 25, 2011 July 26, 2011 July 29, 2011 July 30, 2011 July 31, 2011 In an interview with East Assistant Director of Nursing on 8-26-11 at 1:05 p.m., she indicated the accu-checks were not done. 6. The record of Resident #12 was reviewed on 8/22/11 at 1:00 p.m. Diagnoses for Resident #12 included, but were not limited to, diabetes mellitus and neuropathy. A care plan for Resident #12, dated 5/5/11 and current through 10/2011, indicated a problem of "Potential for hyper/hypo glycemia related to diabetes." The goal was "Will have no signs of symptoms" of high or low blood sugar. Approaches included "meds per order...labs per order...sliding scale per MD order...." A recapitulated physician's order for July 2011, with an original date of 6/27/11, indicated Resident #12 was to receive accuchecks (a finger stick test to measure blood sugar) before meals and at bedtime and she was to receive Humalog insulin according to the following sliding scale: Blood sugar of 250 - 300: 2 units of			

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	insulin Blood sugar of 300 - 350: 4 units of insulin Blood sugar of 350 - 400: 6 units of insulin The physician was to be called if the resident's blood sugar was over 400. A physician's order, dated 7/13/11, indicated Resident #12 was to receive accuchecks three times per day before meals and was to receive Humalog insulin according to the following sliding scale: Blood sugar of 201 - 250: 2 units Blood sugar of 251 - 300: 4 units Blood sugar of 301 - 350: 6 units Blood sugar of 351 - 400: 8 units Blood sugar of 401 - 450: give 10 units Blood sugar of 450 - 500: give 12 units The physician was to be called if Resident #12's blood sugar was less than 70 or over 500. Review of a Blood Glucose/Sliding Scale Coverage Flowsheet for July 2011, received from the East Wing Assistant Director of Nursing on 8/24/11 at 1:05 p.m., indicated Resident #12's blood sugar was not checked on 7/2/11 before breakfast and at bedtime, 7/3/11 before breakfast, 7/4/11 before supper and at bedtime, 7/8/11 before breakfast, lunch and supper, 7/9/11 before breakfast, lunch			

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	and supper, 7/10/11 before breakfast and supper, 7/16/11 before breakfast and supper and 7/30/11 before breakfast, lunch and supper. The Blood Glucose/Sliding Scale Coverage Flowsheet for July,2011, indicated the following: On 7/14/11 insulin was not given for a blood sugar of 210 at 4:00 p.m. Resident #12 should have received 2 units of Humalog. On 7/15/11 insulin was not given at supper time for a blood sugar of 320. Resident #12 should have received 6 units of insulin. On 7/16/11 insulin was not given at supper time for a blood sugar of 276. Resident #12 should have received 4 units of insulin. On 7/20/11 insulin was not given at breakfast for a blood sugar of 208. Resident #12 should have received 2 units of insulin. On 7/14/11 at 6:00 a.m. before breakfast, Resident #12's blood sugar was 58. The record did not indicate the physician was notified. On 8/23/11 at 8:35 a.m., interview with the ADON indicated she was unable to provide any further information on the missing accuchecks, insulin administrations and physician			

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	notification. 7. a. The record of Resident #36 was reviewed on 8/24/11 at 1:30 p.m. Diagnoses for Resident #36 included, but were not limited to, diabetes mellitus, end stage renal disease and morbid obesity. A care plan for Resident #36, originating 7/9/10 and current through 9/2011, indicated a problem of a diagnosis of diabetes with potential for complications. A goal was "Minimize risk for complications from" diabetes. Approaches included "...Accuchecks and insulin per MD order...." A recapitulated physician's order for July 2011, with an original order date of 7/9/10, indicated Resident #36 was to have her blood sugar checked before meals and at bedtime. The physician was supposed to be called if the blood sugar was less than 70 or over 400. Review of a Blood Glucose/Sliding Scale Coverage Flowsheet for July 2011, indicated Resident #36's blood sugar was not checked on 7/2/11 at bedtime, 7/7/11 before supper and at bedtime, 7/14/11 before lunch and bedtime, 7/16/11 before lunch and supper, 7/17/11 before lunch and at bedtime, 7/23/11 before lunch,			

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	7/24/11 before lunch, 7/25/11 at bedtime, 7/28/11 before breakfast and lunch, 7/29/11 at bedtime, 7/30/11 at bedtime and 7/31/11 at bedtime. On 8/24/11 at 4:50 p.m. the West Wing ADON indicated she had no further information regarding the above missing blood sugars. b. A recapitulated physician's order for July 2011, with an original order date of 7/9/10, indicated Resident #36 was to receive Metoprolol 50 milligrams every day for high blood pressure. This medication was not to be given if Resident #36's systolic blood pressure was less than 100 or her heart rate was less than 60. A care plan for Resident #36, dated 7/9/10 and current through 9/2011, indicated Resident #36 had the potential for complications related to her diagnosis of high blood pressure. The goal was to minimize the risk of complications and an approach was "1. Monitor B/P [blood pressure] per MD order...3. Administer meds [medications] per MD order..." Review of a Medication Record for July 2011, for Resident #36 did not indicate the medication was given on July 2, 3, 19 and 20, 2011. It indicated on July 1, 9,			

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	14, 23, 24 and 31, 2011, the medication was given without first checking Resident # 36's blood pressure and heart rate, parameters ordered by the physician prior to giving the medication. During an interview with the West Hall Assistant Director of Nursing on 8/24/11 at 4:50 p.m., she indicated she had no further information to indicate whether Resident #36 received her Metoprolol on July 2, 3, 19 and 20, 2011, or if the blood pressure and heart rate were checked on July 1, 9, 14, 23, 24 and 31 prior to the administration of the medication. An undated facility policy received from the Director of Nursing on 8/24/11 at 3:25 p.m. titled "Preparation and General Guidelines Section 38: Medication Administration - General Guidelines Policy..."Medications are administered as prescribed...C. Documentation 1. The individual who administers the medication dose records the administration on the resident's MAR [Medication Administration Record] directly after the medication is given...." 3.1-35(g)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications, related to the lack of assessment of pain prior to administration of as needed (prn) pain medication and the failure to evaluate the effectiveness of the pain medication administered, for 3 of 8 residents reviewed for pain medications in the sample of 15. Resident #'s 11, 35 and 59. Findings Include: 1) The clinical record for Resident #59 was reviewed on 8/23/11 at 9:15 a.m. Diagnoses for Resident #59 included, but	F0329	**F329 483.25(l) UNNECESSARY DRUGS** It is the practice of Madison Health Care Center to ensure that each resident's drug regimen is free from unnecessary drugs. I. Resident #11 no longer resides in the facility. Residents #35, & #59 are receiving pain medications as needed and are being assessed for pain prior to administration; and assessed again following administration for effectiveness. II. All residents have the potential to be affected. This is being addressed by the systems	09/24/2011

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	were not limited to, depression, edema, hypothyroidism (where the thyroid gland does not make enough thyroid hormone), history of humerus (arm bone) fracture and history of pelvic fracture. A review of the facility Medication Administration Record (MAR) for Resident #59 indicated Resident #59 had a physicians order for Hydrocodone/APAP 7.5/325 mg (Norco, narcotic pain medication), take one tablet by mouth every four hours as needed for moderate pain. The MAR indicated Resident #59 received the pain medication on 7/15/11 at 4:00 p.m. and on 7/16/11 at 5:00 a.m. Documentation was lacking of the location and level of pain, whether the pain medication was effective or of any pain assessment. Further information was requested from the Director of Nursing on 8/24/11 at 5 p.m., about the location and level of pain or pain rating, nurses documentation of pain medication being effective, or any other documentation of an assessment that had been done. During an interview with the Director of Nursing on 8/25/11 at 4:00 p.m., she indicated no further information was		described below. III. The facility policy regarding pain management has been reviewed. Licensed nurses have been re-educated on this policy. The documentation of pain assessment and pain relief will no longer be placed on the medication administration record (MAR) but will be documented on the pain flow sheet. Licensed nurses have been educated on the use of this flow sheet. IV. The Director of Nursing or her designee is conducting quality improvement audits of medication and treatment documentation. A random sample of 5% of resident' s medication records, treatment records, and pain flow sheets are being checked to ensure documentation is complete. This audit will be completed three times weekly for 30 days; then weekly for 30 days; then monthly for 6 months. The pharmacy consultant will assist in monitoring during routine monthly visits. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	

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	available in regard to Resident #59's pain assessments. 2. The record of Resident #11 was reviewed on 8/23/11 at 11:55 a.m. Diagnoses for Resident #11 included, but were not limited to, peri-rectal abscess and end stage renal disease. A physician's order dated 8/16/11, the day Resident #11 was admitted to the facility, indicated he could receive Norco 5/325 milligrams (mg) every 4 - 6 hours as needed, 1 tab for mild pain or 2 tabs for severe pain. Review of a Medication Record and a Controlled Drug Record for Resident #11 for August, 2011, indicated he received 2 Norcos on 8/17/11 at 12:00 p.m., 2 Norcos on 8/17/11 at 8:00 p.m., 2 Norcos on 8/18/11 at 7:30 a.m., 2 Norcos on 8/18/11 at 9:00 p.m., 2 Norcos on 8/21/11 at 8:50 a.m., 2 Norcos on 8/22/11 at 5:00 p.m. and 2 Norcos on 8/23/11 at 12:30 a.m. No documentation was found in Resident #11's record to indicate the location or severity of his pain prior to the administration of the medication or the effectiveness of the medication after administration. During an interview with the Director of			

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	Nursing on 8/24/11 at 11:13 a.m. she indicated she had no further information regarding assessment of the resident's pain prior to and following the administration of Norco. 3. The clinical record for Resident #35 was reviewed on 8/24/11 at 2:00 p.m. The diagnoses for Resident #35 included, but were not limited to: peripheral artery disease, osteoarthritis, and diabetes mellitus type II. The July 2011 physician's recapitulation orders indicated Tylenol 650 mg P.O. (by mouth) q (every) 4 hours PRN (as needed) for pain. The July 2011 MAR (Medication Administration Record) was reviewed on 8/24/11 at 2:30 p.m. It indicated Tylenol 650 mg was given on 7/24/11 (no time indicated), 7/25/11 at 12:00 a.m., 7/28/11 at 3:30 p.m., and 7/29/11 at 3:30 p.m. There was no documentation to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given. Resident #35's care plan for pain was reviewed on 8/25/11 at 12:09 p.m. The care plan indicated an approach was to observe effectiveness of medications.			

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	The Medication Administration-General Guidelines policy provided by the DON on 8/24/11 at 3:05 p.m. was reviewed on 8/25/11 at 12:53 p.m. The policy indicated that when PRN medications are administered, the complaints or symptoms for which the medication was given as well as the results achieved from giving the dose are to be documented. 3.1-48(a)(6)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to ensure dry food was stored in a manner to maintain the integrity of the packaging and to prevent rodent and insect infestation. The facility failed to date frozen perishable food in order to know when to discard the frozen perishable food. This potentially affected 59 residents who ate food from the kitchen of 60 residents residing in the facility. Findings include: A tour of the kitchen was conducted with the Dietary Manager on 8/22/11 at 10:20	F0371	F371 – FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY It is the practice of Madison Health Care Center to ensure that food is stored in a manner to maintain the integrity of the packaging and to prevent rodent and insect infestation. I. The hamburger buns, vanilla wafers, and strawberry cream pie were disposed of at time of observation. II. All residents have the potential to be affected. This is being addressed by the systems described below.III. On 8-23-11 the dietary manager did education with the dietary staff on the facility policy on food storage containing information on labeling and dating open items. IV. The	09/24/2011

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	a.m. During observation of the dry storage area, a package of opened 12 count hamburger buns was observed with a good through date of 8/8/11. Another 12 count package of hamburger buns was observed with a round hole, approximately 3 inches in diameter, in the packaging, exposing the buns to air. A package of opened vanilla wafers was observed in an unsealed package, exposed to air, with no open or use by date on the package. Another package of opened vanilla wafers was observed, sealed, with no open or use by date on the package. During observation of the freezer, an 8 count package of waffles was observed, not in the box, with no open or use by date. Approximately half of a strawberry cream pie was observed with no open or use by date. The Refrigerators and Freezers policy, provided by the Administrator on 8/24/11 at 9:30 a.m., was reviewed on 8/25/11 at 11:01 a.m. The policy indicated supervisors will be responsible for ensuring food items in pantry are not expired or past perish dates. A Dietary Inservice sheet, provided by the Administrator on 8/24/11 at 9:30 a.m. and		Dietary Manager will do a walk thru of food storage areas on each tour of duty.The dietary manager and the dietician will both conduct a sanitation audit of the kitchen which will include food storage. These audits will be done on a monthly basis on a continued basis. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	

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	reviewed on 8/25/11 at 11:12 a.m., indicated after opening a product you must put an open date on the product and all products must have a used by date on the product. The Food Receiving and Storage policy, provided by the Administrator on 8/24/11 at 9:30 a.m., was reviewed on 8/25/11 at 10:55 a.m. The policy indicated all foods stored in the freezer will be dated with a use by date. 3.1-21(i)(3)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record and interview, the facility failed to ensure staff properly cleaned equipment, after use on Residents #16, 25 and 28, to prevent the spread of infection for 3 of 4 residents	F0441	**F441 483.65 (a)(1) INFECTION CONTROL** It is the practice of Madison Health Care Center to maintain an infection control program designed to provide a safe, sanitary, and comfortable	09/24/2011

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	reviewed with a potential to affect 25 of 25 residents residing in rooms assigned for day time care by LPN #1. Findings include: On 8/23/11 at 9:05 A.M. LPN #1 was observed using her stethescope, hanging from her neck and blood pressure cuff she removed from her pocket, to take the blood pressure of Resident # 16 and Resident #25 during the administration of medication, and not cleaning this equipment prior to use on residents, between use, or after use. On 8/24/11 at 10:00 A.M. LPN #1 was observed using her stethescope and blood pressure cuff on Resident #28 to listen to chest sounds when giving a breathing treatment, and did not clean this equipment before use. On 8/23/11 at 10:05 an interview was conducted with LPN #1 who was asked how often she cleans her stethescope and blood pressure cuff between residents. She indicated that she cleans this equipment between "every couple of residents." Review of current facility policy supplied by DON on 8/24/11 at 3:00 P.M. indicates that reusable equipment is not to be used		environment and to help prevent the development and transmission of disease and infection. I. Residents #16, #25, & #28 had no adverse consequences from LPN #1's failure to clean her stethoscope between residents. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. A new policy has been developed that includes cleaning the stethoscope between residents to prevent the potential spread of infection. The cleaning procedure includes the use of an EPA (Environmental Protection Agency) approved germicide. Nursing personnel have been educated regarding this new policy which includes cleaning before and following each use. Blood pressure cuffs and resident equipment will be cleansed with 10% sodium hypochlorite germicide when visibly soiled. Blood pressure cuffs will also be checked weekly to ensure cleanliness. IV. The Director of Nursing or her designee is conducting quality improvement audits of stethoscope cleaning between resident use. A random sample of 5 nursing personnel will be monitored weekly during routine use of the equipment. This QI audit will continue weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's	

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	for the care of another resident until it has been appropriately cleaned and reprocessed. 3.1-18(j)		quality assurance committee monthly for additional recommendations as necessary.	
F0504 SS=D	The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview, the facility failed to ensure there was a physician's order for a lab that was drawn for 1 of 8 residents reviewed for having physician orders for labs in a sample of 15. (Resident #12) Findings included: The record of Resident #12 was reviewed on 8/22/11 at 1:00 p.m. Diagnoses for Resident #12 included, but were not limited to, diabetes mellitus and left femur fracture. Review of labs drawn on Resident #12 included a Comprehensive Metabolic Panel drawn 7/7/11. A physician's order for this lab was not found in the resident's record. During an interview with the East Wing Assistant Director of Nursing on 8/23/11 at 8:35 a.m., she indicated there was no	F0504	**F504 483.75(j)(2)(i)** **LABORATORY SERVICES** It is the practice of Madison Health Care Center to provide or obtain lab services when ordered by the physician. I. Resident #12's physician was notified of the lab test that was done without an order. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. Lab orders are reviewed during morning clinical meeting and checked to ensure that the lab test has been transcribed to the requisition correctly. Nurses have been re-educated on the system for ordering lab tests. IV. The Director of Nursing or her designee is conducting quality improvement audits of lab tests. A random sample of 5% of resident's clinical records are being checked to ensure the lab test that was completed has a	09/24/2011

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	order written for the lab draw. She indicated "She got an extra lab drawn." 3.1-49(f)(1)		current physician's order in place. This audit will be completed three times weekly for 30 days; then weekly for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review, observation, and interview, the facility failed to ensure a resident had physician's orders obtained for oxygen to be discontinued, for 1 of 15 residents whose clinical records were reviewed in a sample of 15 residents. Resident #27. Findings include: Resident #27's clinical record was reviewed on 8/22/2011 at 2:00 p.m. The record contained documentation of Resident #27 having been admitted to the facility on 7/6/2011, with diagnoses that included, but were not limited to,	F0514	**F514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** It is the practice of Madison Health Care Center to maintain each resident's clinical record in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. I. Resident #27's physician was notified and an order was obtained to discontinue the use of oxygen. II. Residents who utilize oxygen	09/24/2011

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	coronary artery disease, dementia, anemia, and hyperthyroidism. A physician order dated 7/6/2011, indicated to titrate oxygen to maintain saturation level greater than 92%. Nurses notes dated 7/9/2011, indicated that saturation was at 98% on oxygen at 3 Liters per nasal cannula. Resident #27 was observed on 8/22/2011 at 2:40 p.m. not wearing oxygen. An interview with the DON (Director of Nursing) on 8/23/2011 at 3:05 p.m., indicated Resident #27 was weaned off oxygen approximately one week after admission to the facility, but there was no documentation regarding exactly when this occurred. Review of the facility's Oxygen Administration Policy, provided by the DON on 8/24/2011 at 11:10 a.m., included, but was not limited to, the following: "After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: the rate of oxygen flow, route, and rationale; the frequency and duration of the treatment; all assessment		have been checked to ensure that the physician's order is correct. III. Licensed nurses have been re-educated to ensure that documentation of oxygen therapy is placed on the treatment administration records (TAR) and if there is a change in the therapy a physician's order should be obtained. Additional systemic changes are being addressed through our quality improvement program as indicated below. IV. The Director of Nursing or her designee is conducting quality improvement audits of oxygen therapy. A random sample of 5% of resident's clinical records are being checked to ensure that if oxygen therapy is in use there is a current physician's order in place. This will include a visual observation of the resident. This audit will be completed three times weekly for 30 days; then weekly for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary	

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	data obtained before, during, and after the procedure." 3.1-50(a)(1) 3.1-50(a)(2)			